

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2015  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |                            |  |
|--|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>155156</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C</b><br><b>03/13/2015</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ARBORS AT MICHIGAN CITY</b> |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1101 E COOLSPRING AVE</b><br><b>MICHIGAN CITY, IN 46360</b>                  |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| {F 000}  | <p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints IN00163785, IN00164923, and IN00164979 completed on 2/26/15.</p> <p>This visit was in conjunction with the PSR to the PSR completed on 2/26/15 to the Recertification and State Licensure Survey completed on 12/5/14.</p> <p>This visit was in conjunction with the PSR to the PSR completed on 2/26/15 to the Investigation of Complaints IN00160464 completed on 12/18/14.</p> <p>This visit was in conjunction with the PSR to the PSR completed on 2/26/15 to the Investigation of Complaint IN00162446 completed on 1/13/15.</p> <p>Complaint IN00163785-Corrected.</p> <p>Complaint IN00164923-Corrected.</p> <p>Complaint IN00164979-Corrected.</p> <p>Survey Dates: March 12 &amp; 13, 2015</p> <p>Facility number: 000076<br/>Provider number: 155156<br/>AIM number: 100271060</p> <p>Survey Team:<br/>Heather Tuttle, RN-TC<br/>Janelyn Kulik, RN<br/>3/12/15</p> <p>Census bed type:<br/>SNF: 33</p> | {F 000}  |  |                            |  |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| {F 000}  | <p>Continued From page 1</p> <p>SNF/NF: 105<br/>Total: 138</p> <p>Census payor type:<br/>Medicare: 34<br/>Medicaid: 90<br/>Other: 14<br/>Total: 138</p> <p>Arbors at Michigan City was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaints IN00163785, IN00164923, and IN00164979.</p> <p>Quality review completed on March 18, 2015, by Janelyn Kulik, RN.</p> | {F 000}  |  |                            |  |